

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

NICOLE MORRISON, as Administrator for the  
Estate of Roberto Grant, and NICOLE MORRISON,  
as Mother and Legal Guardian for the Property of  
AG and SG, Decedent's Minor Children,

Plaintiffs,

v.

UNITED STATES OF AMERICA, *et al.*,

Defendants.

17 Civ. 6779 (WHP)

**DECLARATION OF JENNIFER C. SIMON**

Jennifer C. Simon declares as follows pursuant to 28 U.S.C. § 1746:

1. I am an Assistant United States Attorney in the office of Audrey Strauss, United States Attorney for the Southern District of New York. I am assigned to represent Defendant United States of America, and I am familiar with the facts and circumstances set forth herein. I submit this declaration and the attached exhibits as they were provided to this Office, in support of the Defendant's motion for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure.

2. Attached hereto as **Exhibit A** is a copy of the December 28, 2016 Report of Autopsy performed at the Office of Chief Medical Examiner of the City of New York ("OCME") and obtained from the OCME.

3. Attached hereto as **Exhibit B** is a copy of the Toxicology Report obtained from the OCME.

4. Attached hereto as **Exhibit C** is a copy of the March 11, 2020, Expert Report of Dr. Zhongxue Hua, provided by Plaintiff's counsel.

5. Attached hereto as **Exhibit D** are excerpts from the transcript of the March 26, 2021, Deposition of Dr. Zhongxue Hua.

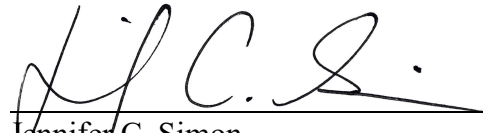
6. Attached hereto as **Exhibit E** is an excerpt from the transcript of the February 24, 2021, Deposition of Roy Timothy Gravette.

7. Attached hereto as **Exhibit F** is a copy of a May 9, 2015, New York Presbyterian Hospital Disposition Note, obtained from the New York Presbyterian Hospital.

8. Attached hereto as **Exhibit G** is a copy of the May 19, 2015, BOP staff memoranda by Officers Dionysia Georgopoulos and Michael Kearins, obtained from BOP.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 2, 2021  
New York, New York

  
Jennifer C. Simon  
Assistant United States Attorney

## Exhibit A



**OFFICE OF CHIEF MEDICAL EXAMINER  
CITY OF NEW YORK**



**REPORT OF AUTOPSY**

**Name of Decedent:** Roberto Grant

**M.E. #:** M-15-003072

**Autopsy Performed by:** Jennifer L. Hammers, D.O. **Date of Autopsy:** May 19, 2015

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**FINAL DIAGNOSES**

- I. BLUNT FORCE TRAUMA OF HEAD, NECK, TORSO, AND EXTREMITIES**
  - A. PETECHIAL HEMORRHAGES OF EYES, PERIORBITAL SOFT TISSUE AND MUSCLE, ORAL MUCOSA, POSTERIOR OROPHARYNX, BASE OF TONGUE, TRACHEA, ESOPHAGUS, AND TEMPORALIS MUSCLES**
  - B. BLOTCHY SCLERA HEMORRHAGES, BILATERAL**
  - C. SUBCUTANEOUS EMPHYSEMA, EYE LIDS AND PERIORBITAL TISSUES**
  - D. DISTENTION OF NECK VEINS AND TEMPORAL VESSELS, MARKED**
  - E. CONTUSION, RIGHT LOWER LIP**
  - F. EXCORIATIONS, ORAL MUCOSA OF LIPS**
  - G. NECK MUSCLE AND SOFT TISSUE HEMORRHAGES, MULTIPLE, BILATERAL**
  - H. TRACHEAL RING HEMORRHAGE, LARGE**
  - I. PERI-CAROTID ARTERY HEMORRHAGES, BILATERAL**
  - J. HEMORRHAGE OF TONGUE, LEFT (1/2")**
  - K. SUBSCALPULAR HEMORRHAGE (3), OCCIPITAL (2" EACH)**
  - L. CEREBRAL EDEMA, MODERATE**
  - M. HEMORRHAGE, LEFT FOREARM MUSCLE (5"), RIGHT ELBOW (1/2"), LEFT SHOULDER (4"), AND RIGHT LATERAL CHEST SOFT TISSUES (1")**
  - N. DEEP LUNG PARENCHYMAL LACERATION (1"), LEFT LOWER LOBE**
  - O. SEE HISTOPATHOLOGY**
- II. NEUROPATHOLOGY EXAMINATION WITHOUT SIGNIFICANT PATHOLOGIC CHANGES**
- III. FOUND IN MULTI-INMATE FEDERAL JAIL CELL, UNRESPONSIVE AND IN CARDIAC ARREST**

- A. STATUS POST CARDIOPULMONARY RESUSCITATION BY MULTIPLE PROVIDERS
- B. FROTH IN BRONCHI

- IV. TOXICOLOGY WITHOUT SIGNIFICANT POSITIVITY
  - A. SYNTHETIC CANNABINOIDS NOT DETECTED
  - B. SEE TOXICOLOGY REPORTS

- V. HYPERTENSIVE CARDIOVASCULAR DISEASE
  - A. CARDIAC HYPERTROPHY (450 GRAMS)
  - B. CONCENTRIC LEFT VENTRICULAR HYPERTROPHY (1.8 CM)
  - C. ARTERIOLONEPHROSCLEROSIS, MODERATE
  - D. TIGHTLY ADHERENT RENAL CAPSULES

- VI. CORONARY ARTERY ATHEROSCLEROSIS, SLIGHT (50%), LEFT MAIN CORONARY ARTERY

- VII. HEPATIC FIBROSIS, UNCERTAIN CAUSE, MODERATE

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CAUSE OF DEATH:

UNDETERMINED

MANNER OF DEATH:

UNDETERMINED

New York City Office of Chief Medical Examiner  
I certify the attached are true copies of  
document(s) in OCME's possession.

Signed

*Yvelisse Matias*  
Yvelisse Matias

Date

*9/16/20*

**OFFICE OF CHIEF MEDICAL EXAMINER  
CITY OF NEW YORK**

**REPORT OF AUTOPSY**

**CASE NO. M-15-003072**

*I hereby certify that I, Jennifer L. Hammers, D.O., Deputy Chief Medical Examiner, have performed an autopsy on the body of **Roberto Grant**, on the 19th day of May, 2015, commencing at 9:30 AM in the Manhattan Mortuary of the Office of Chief Medical Examiner of the City of New York. This autopsy is performed in the presence of Dr. Jason Graham and Dr. Michele Slone. The body is received in the supine position in a plastic body bag which is secured with a white plastic seal bearing the number 54009.*

**EXTERNAL EXAMINATION:**

The body is of a well-developed, well-nourished, muscular, average-framed, 5'10", 204 lb medium brown-skinned Black man whose appearance is consistent with the given age of 35 years. The top of the head exhibits balding and the sides of the head are shaved. There is a goatee that measures up to approximately 1/4" in length and is black in color. The nose and facial bones are palpably intact. The eyes have brown irides and the conjunctivae are without edema or jaundice. The oral cavity has natural teeth in good condition. The top front right tooth is absent and there is well-healed pink mucosa overlying the socket. Within the mouth is a displaced partial denture containing one tooth with the name (CROSS) on the denture. The head, neck, torso, and extremities are with trauma as described below. The hands are not bagged. The hands are atraumatic and the fingernails are neatly trimmed, well-groomed, without breaks, debris or foreign material. The soles of the feet are with slight dry scaly skin and without trauma. The external genitalia are of a circumcised normal adult male. There are scars and tattoos over the body as follows: There is a 2-1/2" x 3/4" well-healed surgical scar on the right shoulder. There is a 1" well-healed linear scar on the right chest just above the breast. There is a 4" x 6" monochromatic professional tattoo on the lateral upper left arm. There is a 1/2" linear scar above and to each side of the right knee. There is a 2-1/2" well-healed linear and vertical scar on the right knee extending inferior along the shin. There is a 1/2" well-healed scar on the upper medial aspect of the left knee. There is a 1" well-healed linear scar and a 1/2" well-healed circular scar on the left mid-thigh. There is a 3/4" monochromatic professional tattoo on the posterior aspect of the left ring finger. There is a 9-1/2 x 2" professional monochromatic tattoo on the anterior left forearm. There are a 4-1/2" and a 3-1/2" transverse linear well-healed

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scar on the upper lateral left torso. There are well-healed surgical scars over the right shoulder, upper back and posteromedial upper arm that measure from superior to inferior, 1/4", 1/4", 1", 1/4", 3/4", 2-1/2" and 2-1/2" on the torso. On the posterior upper arm they measure from superior to inferior 3/4" and 1/4". On the upper back is an 11" x 12" monochromatic professional tattoo. On the posterior right forearm is a 1 x 1/2" well-healed scar and on the posterolateral right thigh is a 6" well-healed vertical scar. Over the arms, hands and legs are a few well-healed irregular scars measuring up to approximately 1/4" each. The left first toenail is thick and yellow. The extremities are without scars overlying subcutaneous veins. There is an OCME toe tag on the right foot.

**POSTMORTEM CHANGES:**

There is marked symmetric rigor mortis of the upper and lower extremities, neck and jaw. Lividity is posterior, purple and unfixed. The body is cool to warm. There is brown material coming from the nares and mouth, present on the face and staining the t-shirt.

**THERAPEUTIC PROCEDURES:**

In place is an endotracheal tube. There is an intravenous line in the left antecubital fossa. There are electrocardiogram leads and defibrillator pads in the body bag. There is a moderate amount of froth in the bronchi. There is a hospital bracelet on the left wrist.

**CLOTHING:**

The body is clad in a white sock on the left foot, a pair of gray sweatpants, a gray T-shirt that has been previously cut, gray boxer shorts, and a pair of white to gray jersey shorts. There is a white sock in the body bag. The clothing is collected and submitted to Evidence.

On the left ring finger is a white and yellow metal band. The band is removed and submitted as personal property to Evidence.

**INJURIES:**

There are blunt force injuries of the head, neck, torso and extremities.

The veins of the neck and the vessels of the temporal regions are markedly distended. A large amount of blood drains from the neck vessels upon reflection of the skin of the neck and upper torso.

The eyelids and periorbital soft tissues are with marked subcutaneous emphysema and the skin of the eyelids is very friable with a small tear occurring at the distal right eyelid upon gentle manipulation for photography. There are abundant petechial hemorrhages in the conjunctiva, sclera, oral mucosa, posterior oropharynx, base of the tongue, trachea, and posterior aspect of the external esophagus. There are large blotchy scleral

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hemorrhages on the lateral aspects of the eyes and smaller blotchy hemorrhages in medial aspects of the eyes.

There is a 1/8" red contusion on the right lower lip. There are several small (less than 1/4") red mucosal excoriations on the inner aspect of the lower lip near the midline and of the right upper lip.

The scalp has no contusion. There are three discrete regions of subscalpular measuring approximately 2" x 2" each, located in the occipital region as follows: left occipital at the posterior aspect of the temporalis muscle, occipital midline, and the right occipital at the posterior aspect of the temporalis muscles. There are abundant petechial hemorrhages in the temporalis muscles, greater on the left than right. There is no skull fracture or epidural, subdural or subarachnoid hemorrhage. The brain weighs 1420 gm and is normal size and shape with moderate cerebral edema and is saved with the spinal cord and dura in formalin for neuropathological examination. A separate report will be issued.

The neck is with evidence of hemorrhage as follows: There is a focal region of hemorrhage in the subcutaneous tissues just lateral to the sternocleidomastoid muscles present both superior and inferior to the mid-aspect of each clavicle. There is a 1 x 1" hemorrhage of the superficial left sternocleidomastoid muscle at the mid-aspect. There is a 1 1/2" x 1/2" hemorrhage in the deep right sternocleidomastoid muscle at the inferior aspect. There is a 1" x 1/2" full thickness hemorrhage of the left sternothyroid muscle extending from the mid-aspect to the superior aspect. There is a 1/4 x 1/4" hemorrhage in the deep left omohyoid muscle at the superior aspect. There is a 1/4 x 1/4" hemorrhage in the deep right omohyoid muscle at the superior aspect. The thyroid gland is without hemorrhage. There is a 1/4" x 1/4" hemorrhage in the left cricothyroid muscle at the lateral aspect. There is 1/4" discrete hemorrhage along the mid-aspect of the carotid artery on each side, at the level of cervical vertebrae 5/6. There is a discrete 3/8" hemorrhage in the right longus colli muscle at the level of cervical vertebrae 5/6. There is a 1/4" hemorrhage over the 6<sup>th</sup> cervical vertebral body in the midline. There is a 1/8" hemorrhage in the lateral aspect of the left longus colli muscle. There are two 1/4" hemorrhages in the left posterior oropharynx adjacent to the epiglottis. There is discrete 1/8" hemorrhage over in the posterior oropharynx adjacent to the cornua of the hyoid bone bilaterally. The hyoid bone is reviewed with anthropology at autopsy and is without trauma. There is discrete hemorrhage in the soft tissues overlying the inferior horns of thyroid cartilage. Between the esophagus and posterior aspect of the upper trachea and lamina of the cricoid is abundant hemorrhage. There is hemorrhage in the fascia overlying the superior horns of the thyroid cartilage. The upper airway is patent. There is hemorrhage of the tracheal rings, primarily at the right anterior lateral and posterior aspects of tracheal rings 5 through the bifurcation with some hemorrhage in the proximal right mainstem bronchus cartilage rings.

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On the posterior neck is a blush of hemorrhage in the bilateral superficial aspect of the semispinalis capitis muscles at the high cervical level. At the mid- to lower cervical levels there is a faint blush of hemorrhage throughout the superficial right semispinalis capitis muscle. There is a discrete 1" x ½" hemorrhage at the medial aspect of the right semispinalis cervicis muscle.

The tongue is with a ½" x ¼" x ¼" hemorrhage within the muscle of the left tongue near the anterior aspect of the tongue and adjacent to the teeth.

The left lower lobe of lung is with a 1" x ½" x ½" laceration deep in the parenchyma and is surrounded by small amount hemorrhage.

There are no abrasions, contusions or lacerations to the skin surface at autopsy. The skin of the extremities, torso, back and face is reflected to reveal the following: There are petechial hemorrhages in the periorbital muscles and soft tissues, greater on the left than right. There is a 5" x 1 ½" x ¼" hemorrhage in the left extensor carpi radialis longus muscle (forearm) at the proximal aspect. There is a ½" hemorrhage over the right elbow at the medial aspect. There is a 4" x 3" x 2" hemorrhage in the left deltoid muscle that extends deep within the muscle. There is a 1" x ½" hemorrhage in the subcutaneous tissues of the right lateral chest overlying ribs 5 and 6. The body is examined the day after autopsy and reveals no additional injuries on the skin surfaces.

*The injuries listed above having been described once will not be repeated.*

#### **INTERNAL EXAMINATION:**

**BODY CAVITIES:** The organs are in their normal situs. The pericardial, pleural and peritoneal cavities contain normal amounts of serous fluid and are without hemorrhage or adhesion. The abdominal wall pannus is 1/4" thick.

**HEAD:** See above.

**NECK:** See above.

**CARDIOVASCULAR SYSTEM:** The heart weighs 450 gm and has a normal distribution of co-dominant coronary arteries with slight (50%) atherosclerotic stenosis of the left main coronary artery. The remaining coronary arteries are without significant atherosclerosis. There is no recent thrombus. The myocardium is homogeneous, dark red and firm without pallor, hemorrhage, softening or fibrosis. The left ventricle wall is 1.8 cm and the right ventricle wall is 0.4 cm thick. The endocardial surfaces and four cardiac valves are unremarkable. The aorta is without atherosclerosis. The venae cavae and pulmonary arteries are patent.

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**RESPIRATORY SYSTEM:** The right lung weighs 770 gm and the left weighs 540 gm. The pink to fluffy parenchyma is with moderate anthracosis but without masses, consolidation or obstruction.

**LIVER, GALLBLADDER, PANCREAS:** The liver weighs 1840 gm and has an intact capsule. The brown parenchyma is with moderate fibrotic texture. The gallbladder contains approximately 10 mL of dark green bile without stones. The pancreas is unremarkable in lobulation, color and texture.

**HEMIC AND LYMPHATIC SYSTEMS:** The spleen weighs 220 gm and has an intact capsule. The color, red and white pulp and consistency are unremarkable. There are no enlarged lymph nodes.

**GENITOURINARY SYSTEM:** The kidneys weigh 160 gm each and have moderately granular red-brown surfaces with unremarkable architecture and vasculature. The ureters maintain uniform caliber into an unremarkable bladder containing 5 mL of cloudy yellow urine. The renal capsules are tight. The prostate is not enlarged. The testes are unremarkable.

**ENDOCRINE SYSTEM:** The pituitary, thyroid and adrenal glands are normal color, size and consistency.

**DIGESTIVE SYSTEM:** The esophagus and gastroesophageal junction are unremarkable. The stomach contains approximately 180 mL of thin green material with very small fragments of round pasta. The gastric mucosa, small intestine and large intestine are unremarkable. The vermiform appendix is present.

**MUSCULOSKELETAL SYSTEM:** The vertebrae, clavicles, sternum, ribs and pelvis are without fracture. The musculature is normally distributed and unremarkable.

**HISTOPATHOLOGY:**

Sections (HT15-01987) are submitted for microscopic examination as follows:

- left tongue at hemorrhage (1) shows a focal region of hemorrhage comprised of intact red blood cells surrounding myocytes.
- right upper hyoid soft tissue (2) shows focal hemorrhage comprised of intact red blood cells surrounding myocytes.
- left sternothyroid muscle (3) shows a focal collection of hemorrhage comprised of intact red blood cells on the surface of the muscle and lacing through the intermyocyte planes.
- right posterior oropharynx (4) shows hemorrhage comprised of intact red blood cells within the muscle and deep soft tissues and a focal hematoma comprised of intact red blood cells within the deep tissue.
- left posterior oropharynx at epiglottis (5) shows focal discrete hematomas of the tissues comprised of intact red blood cells just below the squamous epithelium.

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- left sternocleidomastoid muscle (6) shows hemorrhage comprised of intact red blood cells lacing along intermyocyte planes.
- right sternocleidomastoid muscle (7) shows focal hemorrhage comprised of intact red blood cells within the muscle and lacing along intermyocyte planes.
- tracheal ring near bifurcation (8) shows hemorrhage comprised of intact red blood cells within the respiratory lining along approximately 40% of the width of the tracheal ring. The hemorrhage is present on the left end of the ring and along the right anterior lateral aspect.
- left arm muscle hemorrhage (9) shows a large hematoma comprised of intact red blood cells with serum separation at the edge of the muscle and within the adjacent soft tissue.
- left carotid sheath with hemorrhage, mid (10) shows an unremarkable artery with focal hemorrhage comprised of intact red blood cells present adjacent to the artery and extending into the soft tissues.
- right carotid, inferior, with soft tissue (11) shows unremarkable artery, muscle, and fatty soft tissue with hemorrhage comprised of intact red blood cells throughout the fatty tissue and surrounding nerves, and focally within the muscle.
- heart (12) shows slight myocyte hypertrophy.
- left lung (13) and right lung (15) show slight to moderate intraalveolar and peribronchial pigmented macrophages and slight anthracosis.
- liver and kidney (14) show no significant pathologic changes of the liver. The kidney shows a few sclerotic glomeruli, slight thickening of the medium sized arteries and a rare focal collection of interstitial lymphocytes.
- posterior right neck, semispinalis cervicis muscle (16) shows hemorrhage comprised of intact red blood cells within the muscle and lacing along intermyocyte planes.

**TOXICOLOGY:**

Rapid urine drug screen (Status DS 10 Panel) is negative for common drugs of abuse. Samples are submitted for toxicologic evaluation. A separate report will be issued.

**FORENSIC BIOLOGY:**

Blood specimens and fingernail clippings are submitted to Forensic Biology.

**POSTMORTEM RADIOGRAPHY:**

Postmortem radiographs are taken and retained.

**PHOTOGRAPHY:**

Photographs are taken and retained.

**EVIDENCE:**

Clothing and personal property are collected as evidence.

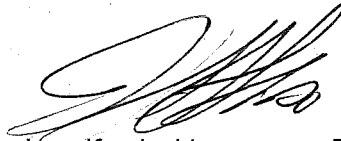
**MOLECULAR GENETICS:**

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**ROBERTO GRANT**

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Heart, liver and spleen specimens are held for molecular genetic studies if needed in the future.

A handwritten signature in black ink, appearing to read 'J. Hammers', is positioned above the printed name.

Jennifer L. Hammers, D.O.  
Deputy Chief Medical Examiner  
December 28, 2016

## Exhibit B

The City of New York  
Office of Chief Medical Examiner  
520 First Avenue  
New York, NY 10016

## Forensic Toxicology Laboratory

Deceased: **Roberto Grant**

M.E. Case No.: **M1503072**

Lab. No.: **1900/15**

Autopsy By: **Dr. Hammers**

Autopsy Date: **05/19/15**

**Specimens Received:**

**Bile, Blood (Femoral), Blood (Heart), Brain, Gastric Content, Liver, Urine (1 of 2)  
Urine (2 of 2), Vitreous Humour**

Specimens Received in Laboratory By: **Doniche Derrick**

Date Received: **05/20/15**

Equivalents: 1.0 mcg/mL = 1.0 mg/L = 0.1 mg/dL = 1000 ng/mL

1.0 mcg/g = 1.0 mg/kg = 0.1 mg/100g = 1000 ng/g

### Results

**Blood (Femoral)**

Ethanol	Not detected	HSGC
Synthetic Cannabinoids	Not detected	NMS*
Benzoylcegonine	Not detected	IA
Barbiturates	Not detected	IA
Oxycodone	Not detected	IA
Opiates	Not detected	IA
Amphetamines	Not detected	IA
Benzodiazepines	Not detected	IA
Methadone	Not detected	IA
Cannabinoids	Not detected	IA

**Urine (1 of 2)**

Cotinine	Detected	GC/MS**
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\*\* Unconfirmed screening result. Confirmation available upon request.

This report has an associated Forensic Toxicology case file.

\* See attached copy of NMS Labs report

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Definitions of terms used in this report can be located at <http://www.nyc.gov/ocme>

IA = Immunoassay	CT = Color Test
GC = Gas Chromatography	TLC = Thin Layer Chromatography
GC/MS = GC/Mass Spectrometry	HS = Head Space
LC = Liquid Chromatography	UV/VIS = Ultraviolet/Visual Spectrophotometry
LC/MS = LC/Mass Spectrometry	< = Less than
CA = Chemistry Analyzer	

Signed: 

William A. Dunn

Date: 09/21/15

EC

**NMS Labs****CONFIDENTIAL**

3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437

Phone: (215) 657-4900 Fax: (215) 657-2972

e-mail: nms@nmslabs.com

Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

**Toxicology Report**

Report Issued 05/28/2015 15:03

To: 10074

New York Office of Chief Medical Examiner  
 Marina Stajic  
 520 First Avenue  
 New York, NY 10016

Patient Name M-15-003072

Patient ID 15-1900

Chain 11798456

Age Not Given DOB Not Given

Gender Not Given

Workorder 15149387

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**Positive Findings:**

None Detected

See Detailed Findings section for additional information

**Testing Requested:**

Analysis Code	Description
9560B	Synthetic Cannabinoids Screen, Blood (Forensic)

**Specimens Received:**

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Miscellaneous Information
001	Red Top Tube	1.25 mL	Not Given	Femoral Blood	

All sample volumes/weights are approximations.

Specimens received on 05/22/2015.



CONFIDENTIAL

Workorder 15149387  
Chain 11798456  
Patient ID 15-1900

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**Detailed Findings:**

Examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded one (1) year from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

**Analysis Summary and Reporting Limits:**

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acocde 9560B - Synthetic Cannabinoids Screen, Blood (Forensic) - Femoral Blood

-Analysis by High Performance Liquid Chromatography/  
TandemMass Spectrometry (LC-MS/MS) for:

<u>Compound</u>	<u>Rpt. Limit</u>	<u>Compound</u>	<u>Rpt. Limit</u>
5F-AB-001	1.0 ng/mL	JWH-018	0.10 ng/mL
5F-APICA	1.0 ng/mL	JWH-081	0.10 ng/mL
5F-APINACA (5F-AKB-48)	2.0 ng/mL	JWH-122	0.10 ng/mL
5F-MN-18	0.10 ng/mL	JWH-210	0.20 ng/mL
5F-PB-22	0.10 ng/mL	MDMB-CHMINACA	0.10 ng/mL
AM-2201	0.10 ng/mL	MN-18	0.10 ng/mL
APICA	0.20 ng/mL	MN-25	0.10 ng/mL
APINACA (AKB-48)	1.0 ng/mL	PB-22	0.10 ng/mL
BB-22	0.10 ng/mL	THJ-018	0.10 ng/mL
FUB-AKB-48	0.20 ng/mL	THJ-2201	0.10 ng/mL
FUB-PB-22	0.10 ng/mL	UR-144	0.20 ng/mL
FUBIMINA	0.10 ng/mL	XLR-11	0.20 ng/mL

-Analysis by High Performance Liquid Chromatography/  
TandemMass Spectrometry (LC-MS/MS) for:

<u>Compound</u>	<u>Rpt. Limit</u>	<u>Compound</u>	<u>Rpt. Limit</u>
5F-ADB-PINACA	1.0 ng/mL	AB-PINACA	0.20 ng/mL
5F-ADBICA	1.0 ng/mL	ADB-FUBINACA	1.0 ng/mL
AB-CHMINACA	1.0 ng/mL	ADB-PINACA	0.20 ng/mL
AB-FUBINACA	1.0 ng/mL	ADBICA	1.0 ng/mL

**THE CITY OF NEW YORK  
OFFICE OF CHIEF MEDICAL EXAMINER  
520 FIRST AVE  
NEW YORK, NY 10016  
FORENSIC TOXICOLOGY LABORATORY**

Deceased: Roberto Grant	Laboratory No.: 1900/15	M.E. Case No.: M15-003072
Autopsy by: Dr. Hammers		Date of Autopsy: 5/19/2015
Specimens received: Femoral Blood X Bile X Urine X (1,2) Gastric Contents X Brain X Liver X Vitreous Humour X Other (specify): Blood (Heart)		
Specimens received in laboratory by: Doniche Derrick		Date Received 5/20/2015

Equivalents: 1.0 mg/L = 1000 ng/mL = 0.1 mg/dL

1.0 mg/Kg = 1000 ng/g = 1.0 mcg/g

**SUPPLEMENTARY REPORT  
RESULTS**

Page 1 of 1

**BLOOD (Femoral)**

Fentanyl - not detected (IA)

**URINE (1 of 2)**

Fentanyl - not detected (IA)

**NOTE:** Please refer to initial report dated 9/21/2015.

This report has an associated Forensic Toxicology case file.

Definitions of terms used in this report can be located at <http://www.nyc.gov/ocme>

CT = Color Test

GC = Gas Chromatography

CA = Chemistry Analyzer

TLC = Thin Layer Chromatography

UV/VIS = Ultraviolet/Visual Spectrophotometry


LC/MS = Liquid Chromatography/  
Mass SpectrometryGC/MS = Gas Chromatography/  
Mass Spectrometry

LC = Liquid Chromatography

IA = Immunoassay

&lt; = Less than

HS = Head Space

Signed: 

Reinaldo Fonseca, BS

Assistant Director, Forensic Toxicology Laboratory

Date: 9/13/2017

AT 09/13/2017

## Exhibit C

Zhongxue Hua, MD-PhD  
Forensic Pathologist and Neuropathologist

March 11, 2020

Andrew C. Laufer, Esq.  
Law Office of Andrew C. Laufer, PLLC  
264 West 40<sup>th</sup> Street, Suite 604  
New York, New York 10015

RE: Roberto Grant (deceased)  
Date of Birth: 3/28/1980  
Date of Death: 5/19/2015

Dear Mr. Laufer:


I, ZHONGXUE HUA, a physician duly licensed to practice medicine in the State of New York, hereby affirm under penalty of perjury and upon information and belief:

1. I am Board Certified in the fields of Forensic Pathology, Neuropathology, and Anatomic Pathology. I maintain an office for the practice of forensic consultation at 415 Main Street, Suite 1C, New York, New York 10044.
2. At your request, I have reviewed the following regarding the death investigation of Roberto Grant by the Office of Chief Medical Examiner (OCME), including autopsy notes (on 5/19/2015), 338 autopsy photographs, case information (on 5/19/2015), police report (on 5/19/2015), toxicology report (on 5/28/2015) by National Medical Services (NMS), neuropathology report (on 6/25/2015), OCME's toxicology report (on 9/21/2015), OCME's supplemental toxicology report (on 9/13/2017), and autopsy report (on 12/28/2016);
3. It is my understanding that at 11:40 p.m. on 5/18/2015, Roberto Grant ("Roberto"), a 35-year-old inmate, was found unresponsive in his cell at the Federal Correctional Facility in Manhattan, New York. After a brief resuscitation, he was pronounced dead at 12:33 a.m. and Dr. Jennifer Hammers performed an autopsy at 9:30 a.m. on 5/19/2015;
5. Autopsy photographs and autopsy report revealed blunt trauma to the head, neck, torso, and extremities. Three (3) postmortem toxicology reports--two at OCME and one at NMS--revealed no acute intoxication by drug, prescription medication, or alcohol. Dr. Hammer's final autopsy report (on 12/28/2016) concluded that both the cause and manner of death were "undetermined";
7. Per autopsy photographs, Roberto had autopsy evidence of neck compression. Specifically, Roberto had multiple, significant, and recent injuries to his neck soft tissues as well as multiple and significant eye petechiae and hemorrhages;
8. Multiple, recent, small, and discrete foci of neck injuries were on both sides of his neck involving the upper, middle, and lower portions. The

(2)

neck injuries were significantly more on the front than on the back of the neck, involving neck blood vessels and multiple neck muscles (including bilateral sternocleidomastoid muscles, bilateral omohyoid muscles, left cricohyoid muscle, and left paraspinal muscles). Although there was not a neck bone fracture, same neck compression marks (manifested as soft tissue hemorrhages) were on the surfaces of the bilateral hyoid bone, inferior thyroid cartilage, and bilateral tracheal rings;

9. I agreed with Dr. Hammers that Roberto had "abundant petechial hemorrhages" in his conjunctivae, sclera, and oral mucosa. Roberto's eyes had more than 50 petechiae hemorrhages;
10. In addition, Roberto had evidence of recent, non-fatal blunt trauma to his head, torso, and extremities;
11. In the absence of any positive finding(s) from three (3) toxicology reports (which were tested from 2015 to 2017), Roberto's inflicted neck compression should and would be considered a valid cause of death;
12. If acute intoxication is still suspected now and the original toxicology specimens (from four years ago) are still available, further toxicology testing could be attempted again. However, an acute intoxication would not explain Roberto's acute, multiple, and significant neck compression and eye petechiae and hemorrhages;
13. Based on my experience both as a practicing forensic pathologist and neuropathologist, within a reasonable degree of medical certainty, it is my considered opinion that Roberto suffered recent, multiple, and significant neck compression in multiple areas of his neck. In the absence of his fatal and acute intoxication or fatal natural disease, Roberto's cause of death should be listed as inflicted and/or homicidal neck compression;
11. I would testify to the above if called as a witness at trial. I reserve the right to amend my findings and opinions in the event additional information comes forth during further legal proceeding.

 3/11/2020  
Zhongyue Hua, MD-PhD  
March 11, 2020

Q

## Exhibit D

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UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

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NICOLE MORRISON, as Administrator  
for the Estate of Roberto Grant,  
and NICOLE MORRISON, as Mother and  
Legal Guardian for the Property of  
AG and SG, Decedent's Minor Children,

Plaintiffs,

-against-

Civil Action No.  
17 Civ. 6779 (WHP)

UNITED STATES OF AMERICA, FEDERAL  
BUREAU OF PRISONS, CORRECTION OFFICER  
KERN, EXECUTIVE ASSISTANT LEE PLOURDE,  
and JOHN AND JANE DOE(s) AGENTS,  
SERVANTS AND EMPLOYEES OF THE DEFENDANTS,

Defendants.

-----  
DEPOSITION OF ZHONGXUE HUA, M.D., a  
Witness herein, taken by Defendants, pursuant  
to Notice, via Zoom, on Friday, March 26,  
2021, at 1:00 p.m., before Monique Cabrera, a  
Shorthand Reporter and notary public, within  
and for the State of New York.

1

2 A P P E A R A N C E S :

3 UNITED STATES DEPARTMENT OF JUSTICE  
4 UNITED STATES ATTORNEY'S OFFICE  
5 Attorney for Defendants  
6 86 Chambers Street  
7 New York, New York 10007

8 BY: JENNIFER SIMON, AUSA

9

10 Law Office of ANDREW C. LAUFER, PLLC  
11 Attorney for Plaintiffs  
12 246 West 40th Street  
13 Suite 604  
14 New York, New York 10018

15 BY: ANDREW C. LAUFER, ESQ.  
16 alaufer@laufer.com

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IT IS HEREBY STIPULATED AND AGREED  
that all objections, except as to the form of  
the questions, shall be reserved to the time  
of the trial;

IT IS FURTHER STIPULATED AND AGREED  
that the within examination may be subscribed  
and sworn to before any notary public with the  
same force and effect as though subscribed and  
sworn to before this court.

1 Dr. Hua

2 intubation cause?

3 A. If you are done properly, you will  
4 not cause much injury. If you are done  
5 improperly, you will cause lots of damage.  
6 You can cause perforation. There are lots of  
7 things that you can talk about here.

8 Q. When you say "perforation,"  
9 perforation of what?

10 A. The tube can be perforated to  
11 different area. Instead of airway it can go  
12 to a different area of the organ and cause  
13 major blood-vessel damage. It really depends  
14 on -- if it's done by EMS or professional  
15 people who have enough training or not.

16 Q. What other injuries can intubation  
17 cause in this case?

18 A. Is it depends on how you treat it,  
19 proper or improperly.

20 Q. If done improperly what injuries can  
21 it cause?

22 A. Improperly you can, instead of  
23 resuscitation of the airway, you can touch a  
24 different portion, a necessary portion of the  
25 body which can cause injuries. It really

1 Dr. Hua

2 depends on where it was performed; done by  
3 professional people, people with training or  
4 not.

5 As I mentioned, it can cause  
6 perforation. Obviously, we do not have  
7 perforation here.

8 Q. Other than perforation, what types of  
9 injuries can intubation cause if not properly  
10 performed?

11 A. Intubation alone, you could cause  
12 tissue damage, wherever the tube is inserted  
13 into. Sometimes people insert tubes properly  
14 in the airway, can cause the mucosa in the  
15 lining of the airway damage.

16 Sometimes can perform inserted  
17 instead of your airway it goes to your food  
18 part, the esophagus area. It really depends  
19 on who did it, what's the experience, whoever  
20 is doing it. Even experienced people can make  
21 mistakes, but fortunately nothing significant  
22 in this case. Airway was properly placed.  
23 There is no perforation.

24 Q. You said that an intubation can cause  
25 tissue damage; where might that tissue damage

1 Dr. Hua

2 occur?

3 A. It depends on where the tube goes.  
4 If it goes to the airway, as I indicated  
5 before, it can cause the airway mucosa damage.  
6 If it goes to the wrong place, into your food  
7 pipe instead of your airway, esophagus, I  
8 mean, first you do not receive oxygen, that's  
9 a big damage. Second, it's not the purpose of  
10 the intubation.

11 Q. Maybe this is another way to approach  
12 it: When someone is intubated and the tube is  
13 properly put in the airway, can you walk me  
14 through all of the tissues that that tube  
15 would come into contact with?

16 A. You mean gently, professionally,  
17 adequately placed or roughly, inadequately  
18 performed intubation inside the airway? I am  
19 not sure what you are actually referring to  
20 here.

21 Q. Let's take them one at a time. If  
22 it's properly done, what tissue might the tube  
23 come in contact with?

24 A. It goes through all the way, from  
25 upper it goes down. It can be rubbing the

1 Dr. Hua

2 lips. Can cause gum damage. Sometimes  
3 people, from the plastic, cause the teeth  
4 damage or mucosa.

5 Backwards a little bit, downward a  
6 little bit, you have the stroke area,  
7 different kinds of mucosa. It really depends  
8 on the tip of the tube, where they bump into,  
9 and even if properly goes down, you can,  
10 inside the airway can cause rubbing against  
11 the side of the mucosa. The inner surface of  
12 the trachea can get damaged to a certain  
13 degree.

14 If you're further down, sometimes it  
15 can improperly go too deep, can cause the main  
16 bronchi damage. It really depends on each  
17 individual case, whether it's placed properly,  
18 professionally or not.

19 All the way down from the start, the  
20 tip of your lip all the way down where's the  
21 tip of the distal end of the endotracheal tube  
22 or worse, along its way there is a potential  
23 damage of anything along its way, yes.

24 Q. Does that include the trachea?

25 A. It should be in the trachea. You

1 Dr. Hua  
2 would expect it to have some degree of damage  
3 in the inner lining inside of the trachea. If  
4 you go outside, then it's a perforation,  
5 that's a different story. I would no longer  
6 characterize it as a properly and  
7 professionally placed airway.

8 Q. Let's take those scenarios one at a  
9 time. If the intubation tube is properly  
10 placed, can you see hemorrhaging in the  
11 trachea?

12 A. Yes.

13 Q. If the intubation tube is improperly  
14 placed, can you see hemorrhaging in the  
15 trachea?

16 A. If properly placed, you would expect  
17 a certain degree, usually a moderate degree of  
18 the airway mucosa damage.

19 Improperly placed really depends on  
20 what improper is. If improper was not even in  
21 the airway, certainly you will not have airway  
22 damage. If you're in the airway and pushing  
23 too hard, too rough, then you would expect  
24 some damage. It also depends on how much  
25 force you're doing it. If you are knowingly

1 Dr. Hua

2 doing it or unknowingly doing it, sometimes it  
3 can be perforated.

4 Q. Looking on the first page of the  
5 autopsy again, the first Roman numeral, Roman  
6 Numeral Number I contains a list of blunt-  
7 force trauma. Do you see that?

8 A. "Blunt-force trauma, head, neck torso  
9 and extremities"?

10 Yes.

11 Q. Do you see under that, it's number E,  
12 as in Edward, it says "Contusion, right lower  
13 lip"?

14 A. Yes.

15 Q. Is that an injury that could occur  
16 with the placement of an intubation tube?

17 A. It's a common side effect of  
18 intubation.

19 Q. And F, where it says "Excoriations,  
20 oral mucosa of the lips." Is that an injury  
21 that could occur as the result of an  
22 intubation tube?

23 A. It's fairly common and insignificant  
24 in a way.

25 Q. What about G, "Neck muscle and

1 Dr. Hua

2 soft-tissue hemorrhages, multiple bilateral,"  
3 are those injuries that could result from the  
4 placement of an intubation tube?

5 A. You can have injury to a certain  
6 degree. The question is multiple, that's  
7 troublesome, especially in conjunction with  
8 other autopsy findings listed A and all the  
9 way down.

10 Q. The injuries listed under G, my  
11 question is simply whether those injuries  
12 could occur as a result of the placement of an  
13 intubation tube?

14 A. Injury could occur. The question is  
15 the key words "multiple" and "bilateral," to  
16 what degree? I mean, no one won't consider  
17 evaluating anything in a vacuum. In the  
18 context of this case, another way to say in  
19 the context of other findings of this case, is  
20 all injury due to intubation? My answer is  
21 "no."

22 Q. I don't think you are quite answering  
23 my question.

24 MR. LAUFER: I believe he did,  
25 counsel, but you can go a bit further. That's

1 Dr. Hua

2 fine.

3 Q. Let me try it a different way.

4 In cases where you have examined a  
5 body, not this one, in cases where you have  
6 examined a body, an individual for whom CPR  
7 was performed who was intubated before their  
8 death, would you have ever observed in those  
9 cases neck muscle and soft-tissue hemorrhages?

10 A. Yes.

11 Q. And in the event that the CPR was not  
12 done well, that it was not done properly, is  
13 it possible that those hemorrhages could be  
14 multiple and bilateral?

15 MR. LAUFER: Objection.

16 You can answer.

17 A. Everything is possible. Just, I  
18 mean, it's possible, yes. The question is, is  
19 it probable in the context of the totality of  
20 this case?

21 Q. Under H it says, "Tracheal ring  
22 hemorrhage large." Is that an injury that  
23 someone could suffer as a result of  
24 intubation?

25 A. If done improperly, yes.

1 Dr. Hua

2 Q. Looking at I, it says, peri-carotid  
3 artery hemorrhages, bilateral," is that an  
4 injury that could occur as the result of the  
5 placement of an intubation tube?

6 A. Unlikely, due to intubation, going in  
7 the context of this case.

8 Q. What are peri-carotid artery  
9 hemorrhages?

10 A. Both side of the neck, right and  
11 left, away from your airway, windpipe, there  
12 is a vessel, artery called the carotid artery,  
13 and tissue nearby has hemorrhaged. In this  
14 case there was no neck line, intravascular  
15 line placed. The presence of bilateral  
16 hemorrhage, the only large answer is some  
17 force being applied on the outside of the neck  
18 caused the corresponding hemorrhage.

19 Q. J, looking at the same list, it says  
20 "Hemorrhage of the tongue." Is that an injury  
21 that could be caused by the placement of an  
22 intubation tube?

23 A. It's very commonly associated.  
24 Again, just like it can be due to the tube or  
25 due to things other than the tube, I would

1 Dr. Hua

2 never put much premium on the tongue injury  
3 alone.

4 Q. Looking at number, in this list, the  
5 one that says, "Petechial hemorrhages of the  
6 eyes. Periorbital soft tissue and muscle,  
7 oral mucosa, posterior oropharynx, base of  
8 tongue, trachea, esophagus and temporalis  
9 muscles."

10 What are petechial hemorrhages?

11 A. It's a small vessel rupture, caused a  
12 pinpointed brain bleeding in a corresponding  
13 area. In this case, we not only have -- in A  
14 was described "petechial." The exact word Dr.  
15 Hammers uses is called "abundant," A B U N D A  
16 N T, on the bottom of Page 4. In this case I  
17 specifically do a rough count of how many  
18 petechial hemorrhages. My counting stopped at  
19 50. There was no point to further count.  
20 It's not like I cannot do it, it's just that I  
21 refuse to waste my time here.

22 MS. SIMON: We are going to take a  
23 ten-minute break. Off the record.

24 (Whereupon, a recess was taken.)

25 MS. SIMON: Let's go back on the

1 Dr. Hua

2 record.

3 BY MS. SIMON:

4 Q. Dr. Hua, you said that petechial  
5 hemorrhages are pinpoint hemorrhages caused by  
6 the ruptured vessels. Do I understand that  
7 correctly?

8 A. Rupture of the small vessels.

9 Q. And I will ask again and, again,  
10 please just answer the question: What can  
11 cause petechial hemorrhages?

12 A. Any reason can potentially cause the  
13 inside of the vessel, the pressure increased,  
14 put through a certain threshold will cause the  
15 petechiae.

16 Q. Can CPR and intubation cause  
17 petechial hemorrhages?

18 A. Improperly, yes. Even a properly  
19 performed can cause slight amount of petechial  
20 hemorrhage. It's not abundant or not, not in  
21 the context of this case.

22 Q. Can improperly done CPR and  
23 intubation cause abundant petechial  
24 hemorrhages?

25 A. In the context of this case, the

1 Dr. Hua

2 answer is no.

3 Q. Why is that?

4 A. Because there are other associated  
5 findings; extensive amount of hemorrhage in  
6 the neck, front and back, right and left,  
7 upper middle and lower portion of the neck,  
8 which all associated with the other finding is  
9 petechial hemorrhage, as well as big patches  
10 of hemorrhage on both sides of the eyes.

11 Q. That's not my question. My question  
12 is: Can improperly done CPR cause abundant  
13 petechial hemorrhages?

14 A. It's a misleading, yes. Yes, it can  
15 cause it, but not in the context of this case.  
16 With "abundant," it's a misleading, yes?

17 Q. I am not asking about another case.  
18 I am asking in general: Can CPR and  
19 intubation improperly performed cause abundant  
20 petechial hemorrhages?

21 A. Extremely unlikely, unless -- can you  
22 define how unprofessional the CPC was  
23 performed? If you can define that, I will  
24 probably give you a better answer.

25 Q. How can improperly done CPR or

1 Dr. Hua

2 intubation cause petechial hemorrhages?

3 A. It's not intubation. It's mainly  
4 because the chest compression can cause  
5 petechial hemorrhages to a certain degree.  
6 It's just compression and the manipulation can  
7 cause the intravascular pressure increase, can  
8 cause some vessel rupture, but not to abundant  
9 degree, especially in the context of this  
10 case.

11 Q. What degree of chest compression  
12 would be required to cause abundant petechial  
13 hemorrhages?

14 A. Only if they're done properly or not.  
15 I mean, we're dealing with petechial  
16 hemorrhage, petechial hemorrhage alone.  
17 Improperly performed over compression of chest  
18 can certainly cause petechial hemorrhage, but  
19 should not cause neck muscle hemorrhage.

20 I mean, no one is dealing with things  
21 in a vacuum and one piece of evidence. It's  
22 in the context of this case, that's what I am  
23 looking at.

24 Q. Again, I just ask that you answer the  
25 question. I am not asking about the context

1 Dr. Hua

2 of this case, I am asking you specifically  
3 what degree of chest compressions can cause  
4 abundant petechial hemorrhages?

5 A. If they're done professionally, it  
6 should not have abundant. There is no -- I  
7 mean the sky is the only limit of  
8 unprofessionally, improper chest compression  
9 which can cause petechial hemorrhages of  
10 various degrees, but again, look at the  
11 context of this case. Otherwise you get a  
12 misleading "yes."

13 Q. I am not asking about this case, I am  
14 asking in general: What degree of chest  
15 compressions can cause abundant petechial  
16 hemorrhaging?

17 MR. LAUFER: Objection. You can  
18 answer.

19 A. If they're done improperly for a  
20 longer period of time, you could cause  
21 significant amount of petechial hemorrhage.  
22 If you can define what "significant," what  
23 "abundant" is, I mean probably Dr. Hammers is  
24 the better one to define. She is the one who  
25 used the word "abundant." The way I look is

1 Dr. Hua

2 more than 50. I don't know if that's your  
3 definition of "abundant."

4 Q. Looking at B in this list, where it  
5 says, "Blotchy sclera hemorrhages bilateral,"  
6 what does that mean?

7 A. It's instead of pinpointed small  
8 vessel hemorrhage, as in the background of one  
9 dot, here with a big patch just like the  
10 autopsy picture demonstrating this picture --  
11 both sides, the large patches instead of  
12 pinpointed breathing spot.

13 Q. Can chest compressions or other  
14 aspects of CPR cause this sort of hemorrhage?

15 A. It depends on how much. It depends  
16 on how chest compressions were performed.  
17 It's potentially, yes.

18 Q. Looking at C, "Subcutaneous  
19 emphysema, eye lids and periorbital tissues,"  
20 what does that mean?

21 A. It means air accumulation in the soft  
22 tissues, which is more related to the  
23 intubation. Was it done properly, over or  
24 under pressure of the outside air, that's why  
25 you have emphysema. It's the air being

1 Dr. Hua

2 accumulated inside the soft tissue.

3 MS. SIMON: Could you read that last  
4 answer back.

5 (Last answer read by the Reporter.)

6 Q. I am going to break that down a  
7 little bit because I am not sure I understood  
8 your answer.

9 So just to make sure I understand  
10 what you are saying, "subcutaneous emphysema"  
11 is air accumulation under the skin; correct?

12 A. Yes, that's the definition of  
13 emphysema. It's air being accumulated in  
14 somewhere, here the subcutaneous, in the soft  
15 tissue underneath the skin.

16 Q. And eye lids, that term fortunately I  
17 do know, but "periorbital tissues" means  
18 around the eyes; right?

19 A. Yes.

20 Q. And what can cause subcutaneous  
21 emphysema?

22 A. Air being trapped into the soft  
23 tissue, which either done properly or  
24 improperly way of doing it causes air being  
25 trapped in the tissue.

1 Dr. Hua

2 Q. So improper CPR can cause  
3 subcutaneous emphysema?

4 A. Improper can cause, just as proper  
5 can cause as well. It's a known side effect.  
6 It's a known, well-documented side effect.

7 Q. And is it a side effect of chest  
8 compressions of the mouth-to-mouth portion of  
9 CPR or intubation or something else?

10 A. It's the pressure being run too high  
11 towards the airway area and also because the  
12 airway, I mean, they probably improperly  
13 positioned the tube; the air was always  
14 running to whatever the least resistant is,  
15 not directly going to the lung, but here going  
16 to the adjacent soft tissues as well.

17 Q. I am just trying to understand what  
18 portion of CPR, but I think you answered it.  
19 You are saying an improperly positioned  
20 intubation tube might cause the air flow to go  
21 somewhere where it's not intended; correct?

22 A. Yes. Even properly performed CPR  
23 would cause airway trapping in soft tissue as  
24 well.

25 Q. In subcutaneous emphysema of the kind

1 Dr. Hua

2 noted here or any other kind, can it look like  
3 bruising, swelling of the skin?

4 A. It's the swelling of the skin, then  
5 bruising of the skin.

6 Q. Look at distension, this is number D  
7 on the same list, "Distention of neck veins  
8 and temporal vessels, marked," what is that?

9 A. Instead of the normal caliber vessel,  
10 here the vessel is very congested. There was  
11 blood to the degree of obvious, to a degree  
12 deserved to be mentioned by Dr. Jennifer  
13 Hammers on the first page of her report. It's  
14 described as a mark in the end.

15 Q. Where are the temporal vessels  
16 located?

17 A. In the temporal area, the side above  
18 your ear, in that region.

19 Q. And the neck veins, I assume, are on  
20 either side of the neck?

21 A. Yes, roughly.

22 Q. Don't let me -- where are they  
23 located?

24 A. There is neck vein on all areas of  
25 neck. Two of the bigger ones on the side and

1 Dr. Hua

2 the small branches in the front, the back, all  
3 over the place.

4 Q. And what can cause distension of neck  
5 veins or the temporal vessels?

6 A. It's inside pressure become high;  
7 therefore, it's dilated, therefore, it's  
8 called marked dilatation as defined by Dr.  
9 Jennifer Hammers.

10 Q. My question is, what can cause it?

11 A. Inside pressure becomes higher than  
12 normally expected to be.

13 Q. What can cause the inside pressure to  
14 become high?

15 A. Any compression of the neck can  
16 certainly cause, any obstruction in different  
17 area can cause, and there is a long list. The  
18 short answer is pressure inside of the vessel  
19 much higher than usual.

20 Q. When you say obstruction of the  
21 airway, could an intubation tube cause harm?

22 A. Not intubation, it's here the  
23 dilatation distention vessels. It is the  
24 inside pressure of the vessel is higher,  
25 nothing to do with the airway per se.

1 Dr. Hua

2 Q. I thought you just said obstruction  
3 of the airway can cause distension of these  
4 things?

5 A. I said it's compression of the neck.  
6 I am not saying -- if I said it, I was  
7 misspoken. Compression of the neck prevents  
8 blood flow, therefore, causing distension of  
9 the vessel. Here we talk about marked degree  
10 of significant degree of distension, as  
11 defined by Dr. Hammers under 1D.

12 Q. Take a step back again, not about  
13 this case specifically, just in general, what  
14 can cause distension of neck veins in the  
15 temporal vessels?

16 A. Anyone can prevent the proper flow of  
17 the blood, can cause the dilatation,  
18 significant dilatation in this case, of the  
19 vessel. Compression of back flow or overflow  
20 -- I mean, here we are dealing with the  
21 vessel. There's always one vessel pumping,  
22 the other vessel coming back.

23 Any elements, any condition can cause  
24 the pressure high, will cause the dilatation  
25 of the vessel. Like in this case we have

1 Dr. Hua

2 significant neck injury, which indicates there  
3 is compression of the neck, which certainly  
4 will be one of the conditions that can cause  
5 significant marked distention of the neck  
6 vessel -- neck vein.

7 Q. You said "any prevention of the  
8 proper flow of blood" can cause distension of  
9 the neck veins and temporal vessels; right?

10 A. Any condition prevented the proper  
11 back circulation of the neck vein, which is  
12 seeding back to your heart. If you prevent  
13 its flow, it will cause the dilatation of the  
14 vessel inside pressure of heart. Compression  
15 of the neck, can certainly do it.

16 Q. Can CPR or intubation cause a  
17 prevention of the proper flow of blood back to  
18 the heart to cause distention of the neck  
19 veins and temporal vessel?

20 A. Potentially, yes. The question is:  
21 To what degree?

22 Q. Look at K in the same list,  
23 "subscapular hemorrhage, occipital, two inches  
24 each;" what do those refer to?

25 A. It's in the occipital back portion of

1 Dr. Hua

2 the head area. Under the skull there is tiny  
3 hemorrhage, three of them; three of them in  
4 total, each about two inches.

5 Q. In your view, Number K, the  
6 subscapular hemorrhages, were they the cause  
7 of Mr. Grant's death?

8 A. It's the general autopsy finding. I  
9 mean, all that means is that pressure being  
10 placed on that particular area. That's why  
11 you have the bleeding in this particular area,  
12 that's all that means.

13 The question is, what is the context?  
14 Why you have this? I do not know. Was it  
15 contributing to anything, contributed nothing,  
16 contributed significantly or a little bit to  
17 the cause of death, I do not know. It's just  
18 simply there.

19 Q. L says "cerebral edema," what is  
20 that?

21 A. Normal brain has its own  
22 configuration. For whatever the reason, lack  
23 of oxygen is one of them, lack of blood supply  
24 is another reason, brain can become -- the  
25 first response of the brain is to become more

1 Dr. Hua  
2 swollen; more fluid accumulation inside, more  
3 congested than usual. That's why, look at  
4 autopsy picture indicating the brain has  
5 moderate degree of swelling and edema, which I  
6 agree with the autopsy picture by Dr. Hammers,  
7 but I understand later on the neural  
8 pathologist just thinks everything is normal.

9 Q. What can cause cerebral edema?

10 A. Lack of oxygen, lack of proper blood  
11 circulation to your brain area. The first  
12 manifestation will be brain swelling edema.  
13 Obviously, head trauma can cause that, we are  
14 not dealing with this. I mean brain trauma  
15 itself can cause swelling edema; obviously, we  
16 are not dealing with that.

17 Q. Looking at M, it says: "Hemorrhage,  
18 left forearm muscle 5 inches, right elbow,  
19 half inch, left shoulder 4 inches, and right  
20 lateral chest soft tissues is 1 inch."

21 A. That's means the bruises hemorrhage  
22 in the different portions of the arm and leg  
23 area as the causal area being found, being  
24 documented as it is.

25 Q. Would any of those hemorrhages have

1 Dr. Hua

2 caused Mr. Grant's death?

3 A. Arm and leg area, obviously not.  
4 Chest area, depends on how it occurred. I  
5 mean, someone had to explain it, why he has so  
6 many bruises at different portions of the  
7 body.

8 According to witnesses there is no  
9 trauma, nothing wrong. It's more, for me,  
10 it's what Dr. Hammers sees, what Dr. Hammers  
11 documented and a further step for me is why  
12 all the other witnesses did not see any  
13 injuries at all.

14 Q. Dr. Hua, if someone fell from a  
15 sitting position or a standing position on to  
16 the floor, could that cause the hemorrhages of  
17 the type that are listed here under M.

18 A. It's unlikely based on the  
19 distribution alone. If you fall, you would  
20 expect the fall, unless you have multiple-  
21 force trauma, you would expect a fall would  
22 cause injury on one plane, right or left,  
23 front or back, and usually on the protruding  
24 portion of the body.

25 Q. Could chest compressions or some

1 Dr. Hua

2 other aspect of CPR lead to a one-inch  
3 hemorrhage on the chest?

4 A. It could, yes.

5 Q. I don't think you answered that.

6 A. I said it could. The short answer is  
7 "yes."

8 Q. Going back to a question I asked  
9 earlier though, is it your understanding that  
10 -- let me rephrase that.

11 The hemorrhages that are listed under  
12 M, could any of them have been fatal?

13 A. By itself, no.

14 Q. Looking at number N, "Deep lung  
15 parenchymal laceration, lower left lobe."

16 What is that referring to?

17 A. It's here Dr. Hammers described the  
18 lower portion of the left lung. There is a  
19 breakage of the tissue, about 1 inch. I do  
20 not see -- at least I cannot find a  
21 corresponding photograph. I don't know what  
22 that means.

23 Q. Is it possible that a lung could be  
24 lacerated when removing it from the body  
25 during the autopsy?

1 Dr. Hua

2 A. Most likely in this case. In the  
3 context of this case, it's the most likely  
4 scenario. I mean, it's a postmortem exam.

5 Q. You mentioned "according to  
6 witnesses"; what witness are you referring to?

7 A. There is a one-page report, the  
8 witness indicated he did not suffer any  
9 trauma, that's my understanding. Witness  
10 indicated he was smoking something which is  
11 not substantiated by subsequent toxicology,  
12 which has indicated he had no trauma, which is  
13 contradicted to subsequent autopsy finding.

14 Q. Where are you reading from?

15 A. I think it's one page.

16 Q. There's a Bates Number in the lower  
17 right corner, perhaps?

18 A. I think I do not have the Bates  
19 Number. It's the only page of the medical  
20 leader investigator, but it's a supplemental  
21 case information by the OCM on May 19th. It  
22 mentioned something, someone saw him, he was  
23 smoking something in the jail cell that  
24 smelled like a marijuana. Also, nobody  
25 indicated he was in the middle of a fight with

1 Dr. Hua

2 anyone.

3 Q. Just looking at the document that we  
4 have marked as --

5 A. Okay, I can pull that page.

6 Q. -- Exhibit B. I just want to make  
7 sure we're referring to the same page.

8 A. All right.

9 Q. What's Bates stamped US\_03606. I  
10 just want to make sure that you have that  
11 page.

12 A. At 3608, mentions some witness saw  
13 him smoking something in the jail cell that  
14 smelled like marijuana.

15 Q. 03608?

16 A. 36608, US\_03608.

17 Q. Other than the information on that  
18 page, did you review any witness statements or  
19 interview notes?

20 A. I was not provided other information.  
21 What I received, what I reviewed will be  
22 listed on the first page of my report, second  
23 paragraph. I did find a mistake of my report,  
24 second paragraph: Total autopsy photo I  
25 reviewed is 332 not 338. I just added up

1 Dr. Hua

2 A. Always look at other information.  
3 Neck injury alone makes it impossible.  
4 Significant neck hemorrhages make it unlikely,  
5 not probable. If there are other findings,  
6 lack of other competing causes of death or  
7 further strengths is building up the case.

8 Q. Do you know whether CPR was done  
9 properly or improperly in this case?

10 A. I would not be in a position to  
11 judge. I was not there.

12 Q. Could improperly performed CPR cause  
13 the type of neck hemorrhages we see in this  
14 case?

15 A. Not to that degree. Not in the  
16 context of this case. It's always look in the  
17 context of the totality of this case -- what  
18 you have, what you do not have. People can  
19 intentionally mislead. To look at this alone,  
20 that's not the way I deal with things. That's  
21 not the way most forensic pathologists are  
22 supposed to deal with things.

23 Q. If CPR were improperly performed here  
24 by amateurs, could it have caused the  
25 hemorrhages in the neck as described?

1 Dr. Hua

2 A. It can cause hemorrhage to a certain  
3 degree, but not to the significant degree as  
4 in this case, especially in the context of  
5 this case, significant petechial hemorrhage  
6 would be unlikely to have a proper explanation  
7 of CPR and CPR alone. And another layer  
8 question, why he needed CPR to start with?

9 There are some people sitting here, I  
10 do not see CPR, unless you have a catastrophic  
11 situation going on do you need CPR is there  
12 any intoxication? Not in this case. Is there  
13 any fatal, immediate fatal natural diseases?  
14 Not according to Dr. Hammers' report.

15 You have to have a reason to need CPR  
16 to start with. There you have a secondary  
17 complication side effect of CPR-related  
18 injury. Why he needs CPR?

19 Q. You mentioned you need to look at the  
20 context to determine a cause of death; what do  
21 you mean by "context"?

22 A. Seeing laceration, witness statement,  
23 gross autopsy, microscopic examination,  
24 toxicology, x-ray examinations, see whether  
25 there is a fit or unfit. At the end of the

1 Dr. Hua

2 day, my job is simple, just whatever is on the  
3 table, did he die of this or die with this?

4 Q. Look at paragraph 8 of your report.  
5 Looking at the last sentence, you refer to  
6 "neck compression marks, manifested as  
7 soft-tissue hemorrhages were on the surfaces  
8 of the bilateral hyoid bone."

9 Did you draw that conclusion from  
10 something in Dr. Hammers' report or from the  
11 photograph?

12 A. I think from Dr. Hammers' report,  
13 that's my recollection. I mean, can be due to  
14 the provided autopsy pictures as well. I am  
15 pretty sure if he incurred what I would  
16 expect, to take a picture of the hyoid bone as  
17 well.

18 Q. Looking at Page 5 of the autopsy  
19 report, about three-quarters the way down it  
20 says: "There is discrete 1/8 inch hemorrhage  
21 over in the posterior oropharynx adjacent to  
22 the cornua of the hyoid bone bilaterally. The  
23 hyoid bone is reviewed without anthropology at  
24 autopsy and is without trauma"?

25 A. I do not see which paragraph.

1 Dr. Hua

2 Q. You concluded that Mr. Grant died of  
3 neck compression; correct?

4 A. In the absence of acute intoxication,  
5 which in my view was not fully ruled on yet.  
6 In the absence of fatal natural diseases, in  
7 my view, was not fully ruled on yet.

8 I am going give to you one example,  
9 people can die of myocarditis. Rule on to  
10 myocarditis, at least you send me five  
11 sections of the heart. Here we have one. We  
12 are not in the position -- we are dealing what  
13 you have.

14 I need to rule on; that's why my  
15 conclusion, it's a conditional conclusion. In  
16 the absence of that, fatal intoxication or  
17 fatal natural diseases, he died of neck  
18 compression.

19 Q. I am going to come back to that in a  
20 moment. I do want to be clear with what my  
21 question is.

22 Based on the hemorrhages and the  
23 other injuries evident in Mr. Grant's body, do  
24 you have an opinion or not about whether  
25 Mr. Grant would have died immediately after

1 Dr. Hua

2 that neck compression or whether a lucid  
3 interval was possible?

4 A. I do not have enough evidence for me  
5 to conclude either way. If the evidence  
6 exists, I want to review in its proper context  
7 instead of a digested opinion in one way or  
8 another.

9 Q. Going back to something that you  
10 said, looking at your Paragraph 13, did I  
11 understand you correctly that the autopsy did  
12 not rule out fatal intoxication?

13 A. If the attempt was done in 2015  
14 unsuccessfully, attempt occurred again nine  
15 months after your report was completed, why  
16 now? Why not now? That's exactly my  
17 paragraph number 12 is about. If it still  
18 exists, do the testing.

19 Q. Based on the records available to  
20 you, can you rule out fatal intoxication?

21 A. Based on the records available to me,  
22 three toxicology reports, not detect anything.  
23 There's no evidence of intoxication as of now,  
24 unless you want to make an argument that  
25 absence of evidence is evidence.

1 Dr. Hua

2 Q. My question is: What additional  
3 testing would need to be performed to rule out  
4 fatal intoxication, in your view?

5 A. I will ask a reliable toxicologist,  
6 first. I mean, I agree with Paragraph 6 of  
7 Dr. Gill's report. I agree that no drugs were  
8 detected. It means not detected, it just  
9 simply means that; "not detected" means not  
10 detected.

11 If you try to say no drug detected,  
12 there must be a drug intoxication, it's just  
13 not the way I use my logic on.

14 Q. Other than the role of a reliable  
15 toxicologist, is there any other additional  
16 testing that you would expect to be able to  
17 rule out fatal intoxication?

18 A. Then ask two reliable toxicologists  
19 or three by that argument, because I am not a  
20 toxicologist. I am not qualified to make a  
21 reasonable, reliable suggestion here. If they  
22 did not see anything, it means no detectable  
23 intoxication.

24 Q. In the case of Mr. Grant, did you  
25 rule out a fatal natural disease?

1 Dr. Hua

2 A. The autopsy report, appears to me,  
3 does not find any significant fatal,  
4 stand-alone natural diseases, but in my view,  
5 it's my case, I will submit more sections of  
6 the heart to rule out the one common disease,  
7 myocarditis. I will submit genetic testing.

8 Here, specifically, Dr. Hammers  
9 mentioned specimen was retained but not  
10 tested. I think the exact wording was  
11 "molecular genetics," at the bottom of page 8  
12 and first line page 9, the top of the page 9,  
13 there is one line here: "Heart, liver and  
14 spleen specimens are held for molecular  
15 genetic studies if needed in the future."

16 Obviously, the specimen is there, it  
17 should be tested. Someone is dead, it's not a  
18 lighthearted matter. It needs to be tested,  
19 it's as simple as that. If it was my case, I  
20 would.

21 MS. SIMON: I think I am wrapping up.  
22 If you can give me five minutes to look at my  
23 notes.

24 (Whereupon, a recess was taken.)

25 MS. SIMON: Back on the record.

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I N D E X

WITNESS	EXAMINATION BY	Page #
Dr. Hua	Ms. Simon	4

E X H I B I T S

Government Exhibit No.	Description	For Ident.
A	Expert disclosure	5
B	Autopsy records and notes	12

PRODUCTION REQUESTS

Page #	Description
67	Doctor's notes

## Exhibit E

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

-----x

NICOLE MORRISON, as Administrator for the  
Estate of Roberto Grant, and NICOLE MORRISON,  
as Mother and Legal Guardian for the Property  
of AG and SG, Decedent's Minor Children,

Plaintiffs,

-against- 17 Civ. 6779 (WHP)

UNITED STATES OF AMERICA, FEDERAL BUREAU OF  
PRISONS, CORRECTION OFFICER KERN, EXECUTIVE  
ASSISTANT LEE PLOURDE, and JOHN AND JANE DOE(S)  
AGENTS, SERVANTS AND EMPLOYEES OF THE DEFENDANTS,

Defendants.

-----x

REMOTE VIDEOCONFERENCE DEPOSITION OF  
ROY TIMOTHY GRAVETTE, a non-party witness herein,  
located in Lafayette, Louisiana 70503, taken by  
the Defendants, pursuant to Rule 26, held on  
Wednesday, February 24, 2021, at 10:30 o'clock  
a.m., before Deborah Moschitto, a Shorthand  
Reporter and Notary Public of the State of New  
York.

1

2 A P P E A R A N C E S:

3

4 LAW OFFICE OF ANDREW C. LAUFER, PLLC  
Attorneys for Plaintiffs  
5 264 West 40th Street - Suite 604  
New York, New York 10018

6

7 BY: ANDREW C. LAUFER, ESQ.  
212-422-1020  
alaufer@lauferlawgroup.com

8

9

10 UNITED STATES ATTORNEY'S OFFICE  
SOUTHERN DISTRICT OF NEW YORK  
Attorneys for Defendant  
11 UNITED STATES OF AMERICA  
86 Chambers Street - 3rd Floor  
12 New York, New York 10007

13 BY: LUCAS ISSACHAROFF, ESQ.

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S T I P U L A T I O N S

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IT IS HEREBY STIPULATED AND

5

AGREED by and between the attorneys for the

6

respective parties hereto, that the filing,

7

sealing and certification of the within

8

deposition be waived; that such deposition

9

may be signed and sworn to before any officer

10

authorized to administer an oath; that all

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objections, except as to the form, are

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reserved to the time of the trial.

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\* \* \*

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1 R. Gravette

2 or let me put it this way: If you knew that  
3 Mr. Grant had died solely due to a K2  
4 overdose or an adverse reaction to K2, would  
5 you believe that his death was attributable  
6 to the negligence or wrongdoing of BOP  
7 officers or guards?

8 MR. LAUFER: Objection. You can  
9 answer.

10 A. If that were the case, I would  
11 have to reconsider my opinions. However, I  
12 do not see that as the case, because he did  
13 have injuries consistent with horseplay and  
14 being choked. That is what was said by  
15 Dr. Hal and from what I read in the Medical  
16 Examiner's report and the other things that I  
17 put in all together.

18 Q. Okay, but I believe that you  
19 state in your report -- hold on a moment.

20 In your report you state that you  
21 do not profess or claim to be a medical  
22 expert or a trained medical professional; is  
23 that correct?

24 A. Yes.

25 Q. And you also state that you can

1 R. Gravette

2 only speculate as to what happened to  
3 Mr. Grant on May 18, 2015; is that correct?

4 A. What page are you reading that  
5 from? Sorry.

6 Q. That's on page 7 of your report,  
7 the first sentence of the second paragraph.

8 A. Yes, that's what it says.

9 Q. If you had credible evidence that  
10 Mr. Grant was, in fact, conversing with other  
11 inmates in his unit when he suddenly  
12 collapsed and lost consciousness, would that  
13 change any of your views or opinions in this  
14 matter?

15 MR. LAUFER: Objection. You can  
16 answer.

17 A. I would have to read those  
18 interviews and see in what context those  
19 interviews were taken and by whom, whose  
20 interviews were taken before I would be able  
21 to opine on that.

22 Q. Before you would be able to opine  
23 on whether they were credible; is that  
24 correct?

25 A. Correct.

1 R. Gravette

2 Q. But if they were credible and if  
3 you had some reason to know or believe that  
4 Mr. Grant was talking and conversing  
5 immediately prior to his loss of  
6 consciousness, would that change your views  
7 in this case?

8 MR. LAUFER: Objection. You can  
9 answer.

10 A. If Mr. Grant was conversing and  
11 suddenly collapsed and we had credible  
12 evidence to support that, then I would have  
13 to re-look at it and see. But I can't tell  
14 you what I would do on "if" information.

15 MR. ISSACHAROFF: Okay. I have  
16 no further questions at this time.

17 MR. LAUFER: I just have a couple  
18 of follow-up, Tim.

19 EXAMINATION BY

20 MR. LAUFER:

21 Q. So I'd like to draw you to page 6  
22 of your report, towards the top. Let me know  
23 when you get there.

24 A. I'm here. I'm there.

25 Q. So this addresses some of the

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## I N D E X

3

WITNESS

EXAMINED BY

PAGE

4

ROY TIMOTHY  
GRAVETTE

Mr. Issacharoff

5-61

5

Mr. Laufer

61-65

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Mr. Issacharoff

65-67

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## E X H I B I T S

11

GOVERNMENT

DESCRIPTION

PAGE

12

Exhibit 1

Report of Tim Gravette,  
produced 12/1/20

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(Government Exhibit 1 attached to transcript.)

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## INFORMATION TO BE SUPPLIED

19

DESCRIPTION

PAGE

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Copy of the witness' notes

29

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\* \* \*

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## Exhibit F

MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

ED Disposition Note [Date of Service: 19-May-2015 01:09, Authored: 19-May-2015 01:09]- for Visit: 000415242 632, Complete, Revised, Signed in Full, General

**ED Vital Signs:**

**ED Vital Signs:**

**1) ED Vital Signs/Assessment FS:**

Date/Time	Heart Rate	SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%)	Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm)	NIBP Systolic	NIBP Diastolic
19-May-2015 00:34	0	0	0	0	0
Position Supine					

**Evaluation:**

**• Evaluation**

pronounced 0033hrs  
 ME case M-15-3072, ME Dr Lazzara  
 Organ donation 2015-022-191, not suitable for  
 donation as per representative Kelly

**ED Diagnosis:**

Problem	Code	Entered Date	Type	Entered By
Cardiac arrest	427.5	19-May-2015 01:08	ED Diagnosis	Mark-Kobashi, Junnie

**Patient Instructions:**

**Prescriptions:**

\* *Outpatient Medication Status not yet specified*

**Outpatient Medications:**

\* *Outpatient Medication Status not yet specified*

**Medication Reconciliation:**

\* I have made a good faith effort to review this patient's home medications. In addition, I have reviewed all medications given during this visit and all new prescriptions.

**I-STOP --> Prescription Monitoring Program Attestation (PMP):**

3. I am not entering a prescription for any schedule II, III or IV drugs to this patient.

**Procedures:**

Procedures were not performed Please Note: This information will be given to the patient.

**NYP I-STOP:**

This patient is at NewYork-Presbyterian Hospital. Practitioners who have or will prescribe, order or administer Schedule II, III, or IV controlled substances for this patient for use during this ED visit or, if admitted on the premises as a result of this visit, are not required to consult the NYS Prescription Monitoring Program (PMP) Registry.

**Disposition:**

Stable.

Disposition: Expired.

**Level of Care:**

Requested by: Laracuente, Raymond (Secretary II), 04-Jun-2015 12:44

Page 1 of 11



MRN: 7567 83 52  
Visit: 000415242 632  
Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
Gender: Male

NY-Presbyterian Low  
Manhattan  
Location: A3

Level of Care Global.

**Electronic Signatures:**

**Mark-Kobashi, Junnie (MD)** (Signed 19-May-2015 02:10)

*Authored: ED Vital Signs, Evaluation, Diagnosis, Patient Instructions, I-STOP -->  
Prescription Monitoring Program Attestation (PMP), Procedures, , Disposition, Level of  
Care*

**Last Updated:** 19-May-2015 02:10 by Mark-Kobashi, Junnie (MD)

\*\*\*\*\*

1) ED Vital Signs/Assessment FS [Authored: 19-May-2015 01:00]- for Visit: 000415242  
632, William, Jasmine (Patient Care Tech); Fazzino, Salvatore (Nurse), Complete, Revised,  
Signed in Full, General

**NURSING COMMENTS**

Comments : ME notified number M15-3072, organ donation also notified

**PERSONAL BELONGINGS**

Personal belongings : Rings no money , no cell phone , no credit card pt came from jail but he  
have one white ring on him , trouser one pair of sock  
Given to : Patient  
Name : pt only have for valuables one white ring. for property 1- trouser nothing else

\*\*\*\*\*

ED Attending Note [Date of Service: 19-May-2015 00:59, Authored: 19-May-2015 00:59]-  
for Visit: 000415242 632, Complete, Revised, Signed in Full, General

**Physician Information:**

**Pre-Assessment Chief Complaint:**

- **Chief Complaint/Subjective:** Cardiac Arrest in Jail. As per EMS, pt was smoking K-2 in jail. Was in Cardiac Arrest X 15 min prior to EMS arrival. + intubated, and CPR in progress upon arrival to ED.

**Triage Comments:**

- **Triage Comments:** As per EMS , pt was smoking K-2 prior to cardiac Arrest. Medics worked on pt. in jail X 35 MIN. + intubation, + IV line insitu. Meds by EMS--Vasopressin 40U, Epi X5 , Narcan 2MG. Pt went into V-Fib and was defibrillated at scene 360J. Upon arrival to ED, No pulse felt. CPR continues. Was in PEA, then Flat Line in ED. Bedside sonogram shows No Cardiac Movement. Pronounced Dead by Dr. Kobashi at 00:33.

**Time Medical Screening Exam Initiated:**

Time: 00:25 Date: 19-May-2015. Performed by Mark-Kobashi, Junnie.

Time Seen by Me (Military Time): 00:25 Date: 19-May-2015.

Requested by: Laracuente, Raymond (Secretary II), 04-Jun-2015 12:44

Page 2 of 11



MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

I have read and reviewed the RN triage assessment, vital signs, pain assessment, allergies, POC test data, and outpatient medications. History From: EMS.

Primary Language English .

Interpreter Needed: No Interpreter's Name.

**History of Present Illness:**

**CC/HPI:**

This patient is a 35 year old Male.

- **Chief Complaint:** EMS notification for cardiac arrest
- **History of Present Illness:** 35 y male, here EMS notification for cardiac arrest. PATIENT MET ON ARRIVAL  
 unknown PMH.  
 Was in his jail, with other cohort prisoners, and pt was witnessed to be smoking some unknown substance (possibly K2/ synthetic marijuana: as per bystander). Pt was found unresponsive, atraumatic, downtime ~15 min, CPR initiated and pt shocked X 4 within the facility by staff, pre EMS arrival.  
 Then EMS found pt still in full arrest, intubated on scene, vasopressin, epi x4, narcan, shocked x 1 for v fib, then PEA, then flatline, total downtime ~35 min with EMS.  
 Therefore, total out of hospital downtime ~50 minutes).  
 ACR #83709334  
 Arrived ER 0025 in PEA then flatline, CPR continued: fixed dilated pupils, no pulse, no rhythm, bedside sono no cardiac activity, pronounced at 0033am by me.

**Associated Symptoms:**

- Chills: UTO
- Fever: UTO
- Nausea: UTO
- Vomiting: UTO
- Diarrhea: UTO
- Abdominal Pain: UTO
- Chest Pain: UTO
- Shortness of Breath: UTO
- Headache: UTO
- Diaphoresis: UTO
- Dizziness: UTO
- Loss of Consciousness: UTO

**Review of Systems:**

- General: UTO
- Skin/Breast: UTO
- Ophthalmology: UTO
- ENMT: UTO
- Respiratory: UTO
- Cardiovascular: UTO
- GI: UTO
- GU/GYN: UTO
- Musculoskeletal: UTO



MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

- Neuro: UTO
- Psych: UTO
- Hematology/Lymphatics: UTO
- Endocrine: UTO
- Allergy: UTO
- Unable to obtain due to: UTO

**Past Medical History:**

- Past Medical History Comments:: UNKNOWN

**Family History:**

- Family History Comments:: UTO

**Allergies:**

- | Allergen/Product         | Description                             |
|--------------------------|---|
| • Allergy Status Unknown | Patient unresponsive, no family present |

**Home Meds / Current Meds Review:**

\* Outpatient Medication Status not yet specified

**Vital Signs - Nursing:**

**Nursing Vitals/POC Tests:**

**1) ED Vital Signs/Assessment FS:**

19-May-2015 00:34

Heart Rate: 0

SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%): 0

Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm): 0

NIBP Systolic: 0

NIBP Diastolic: 0

Position: Supine

**Physical Exam:**

- General: in full arrest
- Eyes: fixed dilated pupils
- ENT: intubated pre arrival , ETT in place
- CV: no heart sound, no pulse
- Lungs: bilateral breath sounds via ETT and BVM
- GI: no bowel sounds
- MSKL - Head/Neck: Atraumatic no signs of head trauma
- Neuro: full arrest, GCS3
- Psych: unable to assess

**Reportable Conditions:**

- Reportable Condition: No

**Attending Assessment and Plan:**

The patient is a 35 year old Male.

- Problem 1: cardiac arrest
- Assessment and Plan: cardiac arrest while in MCC (manhattan correctional center) Federal Jail.  
 No trauma.  
 50 minutes out of hospital downtime, arrive ER at 0025 in PEA/flatline.

Requested by: Laracuent, Raymond (Secretary II), 04-Jun-2015 12:44

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MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

DOA.

Confirmed no signs of life, pronounced at 0033

- **Problem 2:** ME case
- **Assessment and Plan:** case d/w ME Dr Lazzara, case M-15-3072  
 Hospital Reporting Form paperwork filled in chart

**ED Diagnosis:**

Problem	Code	Entered Date	Type	Entered By
Cardiac arrest	427.5	19-May-2015 01:08	ED Diagnosis	Mark-Kobashi, Junnie

**Level of Care:**

Level of Care Global.

**Complete:**

- Note completed by Attending: Yes

**Electronic Signatures:**

**Mark-Kobashi, Junnie (MD)** (Signed 19-May-2015 01:10)

*Authored: Physician Information, Time Medical Screening Exam Initiated, History of Present Illness, Review of Systems, Past Medical History, Allergies, Home Meds / Current Meds Review, Vital Signs - Nursing, Physical Exam, Reportable Conditions, Attending Assessment and Plan, ED Diagnosis, Level of Care, Complete, .*

**Last Updated:** 19-May-2015 01:10 by Mark-Kobashi, Junnie (MD)

\*\*\*\*\*

**ED Trauma Flowsheet [Authored: 19-May-2015 00:59]- for Visit: 000415242 632,**  
 Mark-Kobashi, Junnie (MD), Complete, Entered, Signed in Full, General

**Chief Complaint/Emergency Severity Index**

Chief Complaint/Subjective : Cardiac Arrest in Jail. As per EMS, pt was smoking K-2 in jail. Was in Cardiac Arrest X 15 min prior to EMS arrival. + intubated, and CPR in progress upon arrival to ED.

\*\*\*\*\*

**Death Note (Providers) [Date of Service: 19-May-2015 00:57, Authored: 19-May-2015 00:57]- for Visit: 000415242 632, Complete, Revised, Signed in Full, General**

**Death Note (Providers):**

**Notification:**

- **Date of Death:** 19-May-2015

Requested by: Laracuent, Raymond (Secretary II), 04-Jun-2015 12:44

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MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

**GRANT, ROBERTO**  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

- Time of Death (Military Time): 00:33
- Service: Emergency Medicine
- Name of Attending Physician: J Mark-Kobashi MD
- Was Attending Physician notified? Yes
- Was family member or significant other notified of death? No
- Reason/Plan for Notification: under Federal police custody. Police officers are here at ER

**Medical Examiner/Autopsy:**

- Indications to contact the Medical Examiner; if present, please select and contact the Medical Examiner of NYC at (212)447-2030: Death outside hospital setting
- Was case referred to the medical examiner? Yes
- Name of Medical Examiner: Dr Lazzara
- Medical Examiner Case # : M-15-3072
- Did Medical Examiner accept case? Yes

**Organ Donation:**

- Was the Organ Donor Network notified? Yes
- Case # 2015-022-191 (not suitable for donation)

**Additional Information:**

- Was death the result of a hospital-acquired infection? No
- Pregnant in last 6 months? No
- Did patient have surgery during this admission? No

**Cause of Death:**

- Immediate Cause of Death: Cardiac arrest
- Death due to consequence of: unknown
- Other significant condition(s) contributing to the cause of death: unknown

**Electronic Signatures:**

Mark-Kobashi, Junnie (MD) (Signed 19-May-2015 02:09)

*Authored: Death Note (Providers), Medical Examiner/Autopsy, Organ Donation, Additional Information, Cause of Death*

**Last Updated:** 19-May-2015 02:09 by Mark-Kobashi, Junnie (MD)



MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

\*\*\*\*\*

ED Adult Pre-Assessment Note [Date of Service: 19-May-2015 00:25, Authored:  
 19-May-2015 00:34]- for Visit: 000415242 632, Incomplete, Entered, Signed in Full, General

**Triage Information:**

• **Triage Information**

Nurse Privitera, Jacqueline saw GRANT, ROBERTO at 05/19/15 00:29. The patient has a chief complaint of CARDIC ARREST and was triaged to a level LEV1. Patient was brought TA.

**Travel Assessment:**

- Have you traveled outside the US in the last 21 days? No
- Have you had close contact with someone who had a contagious disease? No

**Quick Triage:**

**Arrival Info:**

Mode of Arrival: Stretcher  
 Means of Arrival: NYP Ambulance  
 Accompanied by: Other POLICE  
 Preferred Language: English

**Chief Complaint/Subjective:**

• **Chief Complaint/Subjective**

Cardiac Arrest in Jail. As per EMS, pt was smoking K-2 in jail. Was in Cardiac Arrest X 15 min prior to EMS arrival. + intubated, and CPR in progress upon arrival to ED.

**Vital Signs:**

- Heart Rate: 0
- Respiratory Rate, Patient (bpm): 0
- SpO2 (Pulse Ox): 0
- NIBP Systolic: 0
- NIBP Diastolic: 0
- Position: Supine

**Mental Status:**

- Mental Status: Unresponsive

**Pain Assessment:**

**Pain Assessment:**

- Pain Scale 0

**Isolation Precautions:**

- Isolation: No

**Allergies:**

- | Allergen/Product         | Description                             |
|--------------------------|---|
| • Allergy Status Unknown | Patient unresponsive, no family present |

Requested by: Laracuent, Raymond (Secretary II), 04-Jun-2015 12:44

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MRN: 7567 83 52  
 Visit: 000415242 632  
 Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
 Gender: Male

NY-Presbyterian Low  
 Manhattan  
 Location: A3

- I have updated or confirmed the items in the allergy manager Yes

**Past Medical & Social History:**

- Past Medical History Comments:: UNKNOWN

**Mandatory Screenings:**

**Tetanus/Immunization:**

- Tetanus: Unsure

**Falls Risk Assessment:**

- Falls Risk: No

**Suicide Risk:**

- In the last month, have you had thoughts of suicide?: No
- In the last month, did you have thoughts that you would be better off dead?: No
- Suicide Risk: No

**Multi-Drug Resistant Organisms:**

- Any history of drug resistant organisms?: No

**Abuse/Neglect/Violence:**

- Any evidence of abuse/neglect/violence?: No

**Reportable Condition:**

- Reportable Condition: No

**Triage Comments:**

**Triage Comments:**

- **Triage Comments:** As per EMS , pt was smoking K-2 prior to cardiac Arrest. Medics worked on pt. in jail X 35 MIN. + intubation, + IV line insitu. Meds by EMS--Vasopressin 40U, Epi X5 , Narcan 2MG. Pt went into V-Fib and was defibrillated at scene 360J. Upon arrival to ED, No pulse felt. CPR continues. Was in PEA, then Flat Line in ED. Bedside sonogram shows No Cardiac Movement. Pronounced Dead by Dr. Kobashi at 00:33.

**Emergency Severity Index:**

- ESI Level 1

**Electronic Signatures:**

**Privitera, Jacqueline (Registered Nurse)** (Signed 19-May-2015 00:54)

*Authored: Triage Information, Travel Assessment, Quick Triage, Past Medical & Social History, Mandatory Screenings, Triage Comments, Emergency Severity Index*

**Last Updated:** 19-May-2015 00:54 by Privitera, Jacqueline (Registered Nurse)

\*\*\*\*\*

# ED Trauma Flowsheet [Authored: 19-May-2015 00:34]- for Visit: 000415242 632,  
 Fazzino, Salvatore (Nurse); Privitera, Jacqueline (Registered Nurse), Complete, Revised,  
 Signed in Full, General



MRN: 7567 83 52  
Visit: 000415242 632  
Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
Gender: Male

NY-Presbyterian Low  
Manhattan  
Location: A3

#### Chief Complaint/Emergency Severity Index

Chief Complaint/Subjective : Cardiac Arrest in Jail. As per EMS, pt was smoking K-2 in jail. Was in Cardiac Arrest X 15 min prior to EMS arrival. + intubated, and CPR in progress upon arrival to ED.

#### Pre-Hospital

Transportation Means of Arrival Means of Arrival : NYP Ambulance  
Transportation Mode of Arrival Mode of Arrival : Stretcher

#### Vital Signs

Vital Signs Temperature (C) degrees C : 36 degrees C  
Vital Signs Temp Source : Temporal  
Vital Signs Heart Rate : 0  
Vital Signs Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm) : 0  
Vital Signs SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%) : 0  
Vital Signs NIBP Systolic : 0  
Vital Signs NIBP Diastolic : 0  
Vital Signs Position : Supine

#### Secondary Survey

Motor/Sensory Mental Status Mental Status : Unresponsive

#### Pain

Pain Assessment Pain Scale : 0

\*\*\*\*\*

**3) Respiratory Flowsheet [Authored: 19-May-2015 00:34]- for Visit: 000415242 632,**  
Privitera, Jacqueline (Registered Nurse), Complete, Entered, Signed in Full, General

#### PULSE OX

Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm) : 0  
SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%) : 0

\*\*\*\*\*

**1) ED Vital Signs/Assessment FS [Authored: 19-May-2015 00:34]- for Visit: 000415242 632,**  
Fazzino, Salvatore (Nurse); Privitera, Jacqueline (Registered Nurse), Complete, Revised, Signed in Full, General

#### VITAL SIGNS

Requested by: Laracuente, Raymond (Secretary II), 04-Jun-2015 12:44

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MRN: 7567 83 52  
Visit: 000415242 632  
Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
Gender: Male

NY-Presbyterian Low  
Manhattan  
Location: A3

Temperature Temperature (C) degrees C : 36 degrees C  
Temperature Temp Source : Temporal  
Heart Rate : 0  
SpO2 SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%) : 0  
SpO2 Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm) : 0  
Blood Pressure NIBP Systolic : 0  
Blood Pressure NIBP Diastolic : 0  
Blood Pressure Position : Supine

#### PAIN ASSESSMENT

Pain Assessment Pain Scale : 0

#### NURSING COMMENTS

Comments : pt received in cardiac standstill, Intubated CPR in progress, pt however remained in cardiac stanstill, pupils dilated and fixed MD at bedside, pt pronounced

#### FALL ASSESSMENT

Fall Assessment Falls Risk : No

\*\*\*\*\*

**Cardiac Arrest Flowsheet - Adults [Authored: 19-May-2015 00:33]- for Visit: 000415242**  
632, Fazzino, Salvatore (Nurse); [Signed by: Privitera, Jacqueline (Registered Nurse)19-May-2015 05:24], Complete, Not Revised, Signed in Full, General

#### CARDIAC ARREST INFO

Cardiac Arrest Info Location : prior to arrival in jail  
Cardiac Arrest Info Arrest Observed : Unwitnessed  
Cardiac Arrest Info Monitored : No

#### PATIENT STATUS

Mental Status : Unconscious

#### VITAL SIGNS

Heart Rate Rate : 0  
Rhythm : asystole  
Resp Rate, patient : 0

#### INTERVENTIONS

CPR : In progress  
Ventilation : ETT by EMS  
FIO2 : 100%

Requested by: Laracuento, Raymond (Secretary II), 04-Jun-2015 12:44

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MRN: 7567 83 52  
Visit: 000415242 632  
Age: 35y (28-Mar-1980)

GRANT, ROBERTO  
Gender: Male

NY-Presbyterian Low  
Manhattan  
Location: A3

PATIENT OUTCOME

Patient Outcome : Expired  
Time of Expiration : 00:33

\*\*\*\*\*

ED Trauma Flowsheet [Authored: 19-May-2015 00:33]- for Visit: 000415242 632, Fazzino,  
Salvatorre (Nurse), Complete, Entered, Signed in Full, General

Patient Outcome

Patient Outcome : Expired  
Time of Expiration : 00:33



## Exhibit G



## UNITED STATES GOVERNMENT MEMORANDUM

Metropolitan Correctional Center, New York, New York

DATE: 05/19/2015

TO: Operations Lieutenant Delany

FROM: SOS M. Kearins

THRU: N/A

SUBJECT: Inmate Grant, Roberto 69913-054

At approximately 11:40 PM while I was performing duties as Unit K-S OIC several inmates from 12 tier called for my assistance. When I arrived at the gate area there were several inmate in the area of inmate Grant's, Roberto 69913-054 bunk stating that inmate Grant, Roberto 69913-054 was not well. Upon the arrival of additional staff we entered the tier and observed that inmate Grant, Roberto 69913-054 was unresponsive. CPR was immediately commenced on this inmate by myself and other staff. The defibrillator was then used but no response was seen by the use of the machine. The inmate was then placed on a stretcher and removed from the Unit to be taken to a outside hospital for care.



## UNITED STATES GOVERNMENT MEMORANDUM

Metropolitan Correctional Center, New York, New York

DATE: 05/19/2015

TO: Operations Lieutenant Delany

FROM: CO-D. Georgopoulos

THRU: N/A

SUBJECT: Inmate Grant, Roberto 69913-054

At approximately 11:40 PM on May 18, 2015, some inmates verbalized "CO" from 12 tier. Once I approached the grill door for 12 tier I noticed a few inmates moving quickly. One inmate was spraying a substance in the air. Two inmates were by the grill and stated that medical help was needed. I asked for whom and verbalized to the inmates that assistance will be called. Officer Kearins radioed for medical and staff assistance. I walked towards the sallyport and grabbed the stretcher and brought it to the unit and placed it by the grill area. Once staff arrived, we unlocked the tier and approached Inmate Grant who was laying in a bottom bunk to the left side of the tier and was not responding to us. Inmate Grant had drool on the side of his mouth and had a wet stain visible through his grey sweatpants. Officer Kearins checked his pulse and none was felt. Once Inmate Grant was moved from the bed to the floor, I started chest compressions and Officer Kearins gave the breaths. We continued CPR until Lt. Delaney brought the defibrillator and we followed the instructions as the defibrillator dictated to us. When the stretcher arrived, Inmate Grant was moved to the stretcher and CPR continued. Once Inmate Grant was moved out of the unit, I secured the grill door for 12 tier. I re-entered 12 tier with two other staff members to remove Inmate Grant's identification card and locked the grill door for tier 12 again.